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RELEASE OF INFORMATION

DATE:

I, ______________________, authorize Hartstein Psychological Services, to discuss my information and treatment with the following parties:

1) Name: ____ Affiliation: _____________________

Address: ____

Phone numbers: ____

Email address: ____

2) Name: ____ Affiliation: _____________________

Address: ____

Phone numbers: ____

Email address: ____

I authorize Hartstein Psychological Services to discuss any pertinent psychological and medical background information and current issues of concern with the named parties.

I understand this authorization will remain in effect throughout the course of treatment. I may revoke authorizations at any time.

Date: ______________________

Name of client (print):____

Signature of client: ____

Name of party accepting authorization (print): ____

Signature of party accepting authorization: ____